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8 DEONTE R. R.,
9 Plaintiff,
10 v.
11 ANDREW SAUL,
12 Defendant.

Case No. 19-cv-03251-RMI

**ORDER ON CROSS MOTIONS FOR
REMAND**

Re: Dkt. Nos. 38, 39

13
14 Plaintiff, seeks judicial review of an administrative law judge (“ALJ”) decision denying his
15 application for supplemental security income under Title XVI of the Social Security Act.
16 Plaintiff’s request for review of the ALJ’s unfavorable decision was denied by the Appeals
17 Council, thus, the ALJ’s decision is the “final decision” of the Commissioner of Social Security
18 which this court may review. *See* 42 U.S.C. §§ 405(g), 1383(c)(3). Both parties have consented to
19 the jurisdiction of a magistrate judge (dkts. 20 & 22), and both parties have moved for remand
20 (dkts. 38 & 39) while disagreeing only about the nature of the remand. For the reasons stated
21 below, Plaintiff’s motion for remand for calculation and payment of benefits is granted, and
22 Defendant’s motion for remand for further proceedings is denied.

23
LEGAL STANDARDS

24 The Commissioner’s findings “as to any fact, if supported by substantial evidence, shall be
25 conclusive.” 42 U.S.C. § 405(g). A district court has a limited scope of review and can only set
26 aside a denial of benefits if it is not supported by substantial evidence or if it is based on legal
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28 ¹ Pursuant to the recommendation of the Committee on Court Administration and Case Management of the
Judicial Conference of the United States, Plaintiff’s name is partially redacted.

1 error. *Flaten v. Sec'y of Health & Human Servs.*, 44 F.3d 1453, 1457 (9th Cir. 1995). The phrase
 2 “substantial evidence” appears throughout administrative law and directs courts in their review of
 3 factual findings at the agency level. *See Biestek v. Berryhill*, 139 S. Ct. 1148, 1154 (2019).
 4 Substantial evidence is defined as “such relevant evidence as a reasonable mind might accept as
 5 adequate to support a conclusion.” *Id.* at 1154 (quoting *Consol. Edison Co. v. NLRB*, 305 U.S.
 6 197, 229 (1938)); *see also Sandgathe v. Chater*, 108 F.3d 978, 979 (9th Cir. 1997). “In
 7 determining whether the Commissioner’s findings are supported by substantial evidence,” a
 8 district court must review the administrative record as a whole, considering “both the evidence
 9 that supports and the evidence that detracts from the Commissioner’s conclusion.” *Reddick v.*
 10 *Chater*, 157 F.3d 715, 720 (9th Cir. 1998). The Commissioner’s conclusion is upheld where
 11 evidence is susceptible to more than one rational interpretation. *Burch v. Barnhart*, 400 F.3d 676,
 12 679 (9th Cir. 2005).

13 PROCEDURAL HISTORY

14 In September of 2016, Plaintiff filed an application for supplemental security income,
 15 alleging an onset date of January 3, 2012. *See* Administrative Record “AR” at 11.² As set forth in
 16 detail below, the ALJ found Plaintiff not disabled and denied the application on May 21, 2018. *Id.*
 17 at 11-22. The Appeals Council denied Plaintiff’s request for review on April 11, 2019. *See id.* at 1-
 18 4. In this court, Defendant confesses error and submits that a remand for further proceedings is
 19 necessary due to the ALJ’s errors in analyzing the medical opinion evidence as well as Plaintiff’s
 20 subjective complaints (*see* Def.’s Mot. (dkt. 39) at 1-2), however, Plaintiff submits that the case
 21 should be remanded with instructions to calculate and award benefits without further proceedings
 22 (*see* Pl.’s Mot. (dkt. 38) at 23).

23 SUMMARY OF THE RELEVANT EVIDENCE

24 Born in 1991 to parents that were afflicted with chronic homelessness and substance abuse
 25 problems, Plaintiff experienced trauma during his early years, such that he began psychotherapy
 26 when he was only eight years old. *See AR* 424-25, 523-25. Plaintiffs’ early years were largely
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28 ² The AR, which is independently paginated, has been filed in several parts as a number of attachments to Docket Entry #29. *See* (dkts. 29-1 through 29-13).

1 spent living on the streets interspersed with occasional periods of respite in motel rooms. *Id.* at
2 523. During those years, he was a frequent witness to the beatings his mother endured at the hands
3 of his father. *Id.* As recently as 2017, he reported that his father was still homeless but that his
4 mother was in a substance abuse rehabilitation program. *Id.* at 523-24. More recently, due to his
5 history of psychiatric problems, Plaintiff has been unable to manage social interaction and, thus,
6 he has been living in a socially isolated state. *Id.* at 524.

7 While managing to graduate from high school, Plaintiff did so under a regime of special
8 education and with the help of resource classes due to problems with his memory and his slow
9 functioning. *Id.* Following high school, he attempted to complete some coursework at San
10 Francisco City College, however, he was eventually forced to abandon that effort due to not
11 having a stable place to live and not being able to pay his bills. *Id.* Thereafter, he briefly held a job
12 as a security guard, however, Plaintiff lost that job due to difficulties in arriving on time to start
13 his shift, and due to being slow in the performance of his duties once there. *Id.* As a youngster, he
14 had been incarcerated several times for various misdemeanors including being jailed for stealing
15 clothes at a time when he was too poor to support himself. *Id.* This was the same period which saw
16 the onset of his history of head trauma and unconsciousness due to having his head smashed onto
17 the concrete four times during a fight. *Id.*

18 Between 2016 and 2017, Plaintiff's primary care providers at Lifelong Trust Medical Care
19 diagnosed him with a number of conditions that included: a recurrent and severe case of major
20 depressive disorder with psychotic features; posttraumatic stress disorder ("PTSD"); and, a
21 schizoaffective disorder of the depressive type. *Id.* His treatment providers found that Plaintiff also
22 suffered from anxiety, agitation, paranoia in the community, command auditory hallucinations,
23 anhedonia, disorganization, tearfulness, feeling overwhelmed, negative thoughts, isolation from
24 peers, as well as difficulties in handling conflict, sleeping, and setting boundaries. *Id.* As for the
25 auditory hallucinations, Plaintiff reported hearing "voices that were mean and degrading and
26 telling him to do bad things"; and, in order to mitigate the effects of these symptoms, he has
27 habitually avoided public places or the company of others, preferring instead to focus his attention
28 on tasks like drawing, which helped to keep him calm. *Id.* at 534-25. In the course of their

1 treatment sessions, Plaintiff's primary care providers found that he presented as very childish and
2 immature, and that he frequently manifested tangential thinking, a flat affect, impaired insight and
3 judgment, problems with attention and concentration, and depressive paranoid ruminations and
4 preoccupations. *Id.* at 525.

5 **Medical Evidence**

6 The record in this case reflects that Plaintiff underwent three consultative psychological
7 evaluations between January of 2016 and August of 2017, culminating in three separate
8 psychological reports. *See id.* at 424-28, 470-73, 522-35. Additionally, in January of 2018, Dr.
9 Ted M. Aames, his treating psychologist at Lifelong Trust Medical Care completed and submitted
10 a Mental Impairment Questionnaire in which he also opined about Plaintiff's impairments and
11 their consequential limitations on his ability to work. *Id.* at 536-40.

12 **Consultative Examiners**

13 In January of 2016, Plaintiff was referred for an evaluation by Jonathan Howard, Psy.D.,
14 "for the purposes of providing an assessment of occupational disability and diagnostic impressions
15 to the Social Services Administration." *Id.* at 424. Dr. Howard's psychological evaluation
16 included a clinical interview, a mental status examination, an administering of both parts of the
17 Trail Making Tests ("TMT"), the Fourth Edition of the Wechsler Adult Intelligence Scale
18 ("WAIS-IV"), and the Fourth Edition of the Wechsler Memory Scale ("WMS-IV"). *Id.* Regarding
19 daily activities, Plaintiff reported to Dr. Howard that he was living with a friend in Oakland at the
20 time, that he was receiving no income, and that he required assistance with tasks as basic as
21 cooking, shopping, and cleaning. *Id.* He also informed Dr. Howard about his history of depression,
22 anxiety, and his difficulties with learning and memory – all of which were rooted in his early
23 adolescence. *Id.* at 425. In addition to his longstanding issues with depressed mood and anxiety,
24 Plaintiff also reported sleep disturbances, tearfulness, decreased appetite, decreased energy,
25 irritability, paranoia in relation to pervasive thoughts that people are trying to hurt him, as well as
26 impaired faculties regarding memory and concentration. *Id.* In describing his four-year struggle
27 with auditory hallucinations, as well as his history of suicidal ideations, Plaintiff also noted that he
28 had entertained suicidal thoughts as recently as two weeks before the evaluation. *Id.* The mental

1 status examination revealed issues with his intermediate memory in that he was unable to recall 2
2 out of 3 words after five minutes; his attention and concentration also appeared impaired in that he
3 was unable to count backwards by units of three or to perform a simple arithmetic operation by
4 subtracting \$7.50 from \$18.00. *Id.* Upon administering the WAIS-IV instrument for cognitive
5 function, Dr. Howard calculated Plaintiff's full scale IQ score at 61, placing him in the "extremely
6 low" range of intellectual function, or, at the bottom 0.5 percentile. *Id.* at 426. Similarly,
7 Plaintiff's performance on the WMS-IV indicated severe impairment in the various aspects of his
8 memory function. *Id.*

9 Dr. Howard diagnosed Plaintiff with an unspecified mood disorder that was attended with
10 depressed, anxious, and psychotic features; an unspecified cognitive disorder; a substance abuse
11 disorder related to cannabis consumption; and, Dr. Howard also noted that an unspecified
12 psychotic disorder might need to be ruled out. *Id.* The cognitive disorder diagnosis was based on
13 the above-discussed test results which indicated slowed psychomotor ability and difficulty in
14 shifting mental sets, while showing moderate impairment as to verbal comprehension, but severe
15 impairments as to perceptual reasoning, working memory, processing speed, immediate memory,
16 and the ability to learn or recall auditory or visual information. *Id.* at 426-27. In the end, Dr.
17 Howard found that Plaintiff's overall cognitive abilities were severely impaired. *Id.* at 427. As to
18 Plaintiff's abilities, Dr. Howard opined that he suffered from a moderate to marked impairment in
19 his ability to understand and execute simple instructions and tasks, but that he suffered from
20 marked impairment in the following categories: understanding and executing more complex
21 instructions and tasks; paying attention and concentrating in ordinary work situations; adapting to
22 changes in the working environment; interacting with people; maintaining pace and persistence on
23 tasks; performing activities within a set schedule; and, maintaining regular attendance. *Id.* At
24 bottom, Dr. Howard concluded that Plaintiff would even "need assistance in managing his funds
25 towards his own best interest." *Id.*

26 A few months later, in August of 2016, Plaintiff was referred to Aparna Dixit, Psy.D., by
27 the state disability agency for another consultative examination. *Id.* at 470-73. At the outset it
28 should be noted that it is unclear what records, if any, Dr. Dixit reviewed in conjunction with this

1 evaluation as her report only mentions that “available” records were reviewed without any further
2 elaboration or mention of the records that were available for her review. *Id.* at 470. In any event,
3 Dr. Dixit conducted a clinical interview and a mental status examination, while also administering
4 the WAIS-IV, the WMS-IV, and the TMT. *Id.* On this occasion, Plaintiff’s full scale IQ was
5 determined to be 80 (while explaining the score to fall within the low average range); his index
6 scores on the WMS-IV were determined to be 91 (auditory memory index) and 90 (visual working
7 memory index), which Dr. Dixit characterized as falling within the average range; and, lastly,
8 Plaintiff’s performance on the TMT “suggested mild impairment in the domain of sequencing,
9 organizing, and mental flexibility.” *Id.* at 471-72. Assessing a GAF (Global Assessment of
10 Functioning) Score of 61, Dr. Dixit diagnosed Plaintiff with Dysthemic Disorder (also known as
11 persistent depressive disorder). *Id.* at 472. As to his work-related ability to function, Dr. Dixit
12 found that Plaintiff suffered from no limitations whatsoever in the following areas: following and
13 remembering simple instructions; maintaining adequate pace and persistence such as to perform
14 single-step or two-step repetitive tasks; maintaining emotional stability and predictability;
15 interacting with coworkers and supervisors; and, communicating (verbally or in writing)
16 appropriately with others. *Id.* at 472-73. On the other hand, Dr. Dixit opined that Plaintiff suffered
17 only mild limitations in the remaining categories of work-related functioning: following and
18 remembering complex instructions; maintaining adequate persistence and pace such as to perform
19 complex tasks; maintaining adequate attention and concentration; adapting to changes in the job
20 routine; withstanding the stress of a routine workday; interacting appropriately with the public;
21 and, performing tasks requiring mathematical skills. *Id.* Dr. Dixit also held the opinion that
22 Plaintiff was incapable of managing his own funds. *Id.* at 473. Finally, it should be noted that Dr.
23 Dixit’s report was not very detailed and consisted of little more than 3 pages, much of which
24 appears to be boilerplate. *See id.* at 470-73.

25 Almost exactly one year later, in August of 2017, Plaintiff was referred to Katherine
26 Weibe, Ph.D., for another psychological evaluation; in the course of which, the following
27 procedures were administered: the Repeatable Battery for the Assessment of Neuropsychological
28 Status (“RBANS”); the Annotated Mini Mental State Examination (“AMMSE”); the Clock

1 Drawing test; the Barona IQ Estimate; the TMT; the Beck Depression Inventory (“BDI-II”); the
2 Beck Anxiety Inventory (“BAI”); and the Mental Status / Psychiatric Symptoms Sheet. *Id.* at 522,
3 526. In addition to these procedures, Dr. Weibe also conducted an extensive clinical interview and
4 a thorough review of Plaintiff’s medical records from his psychotherapy treatment providers at
5 Lifelong Trust Medical Care spanning from August of 2016 to June of 2017 – all of which was
6 memorialized in Dr. Weibe’s 14-page report. *Id.* at 523, 526.

7 Initially, based on her review of Plaintiff’s medical records (all of which were dated *after*
8 the date of Dr. Dixit’s above-discussed evaluation), Dr. Weibe noted that Plaintiff’s treating
9 psychotherapists had diagnosed him with a severe and recurrent major depressive disorder, PTSD,
10 and a depressive type of schizoaffective disorder. *Id.* at 523. As a result of these conditions,
11 Plaintiff’s medications include risperidone (an antipsychotic medication which, incidentally,
12 causes Plaintiff to suffer tremors) and trazadone (an antianxiety and antidepressant medication).
13 *Id.* As a result of the functional and mental status exams, Dr. Weibe made the following
14 observations and findings: that Plaintiff has impairments in insight, judgment, and reasoning
15 (affecting his ability to manage his personal affairs); that he refrains from shopping for himself
16 due to his fear of his urge to steal things; that he generally eats fast food or microwavable meals;
17 that despite finding cleanliness very important, when Plaintiff is depressed “he does not even
18 shower and does not go out anywhere”; that he sometimes has difficulties on public transportation
19 due to his paranoia; that he has problems making change or keeping track of money (“his
20 roommate does this for him”); that he evidenced a childlike manner and inexplicably referred to
21 himself in the third person; that he displayed a depressed mood coupled with tension, irritability,
22 and ambivalence; that he evidenced problems with memory coupled with the inability to discuss
23 prior traumatic events for fear of crying; that he evidenced tangential speech, a tendency to
24 become easily confused, frustrated, anxious, and impatient; that he expressed some suicidal,
25 paranoid, and delusional ideations; that he reported feelings of hopelessness, guilt, and
26 worthlessness, coupled with derogatory and command auditory hallucinations; and, that his
27 problems with insight, judgment, and reasoning were associated with his psychiatric and
28 personality disorder problems. *Id.* at 525-26.

1 As to his test results, based on the Barona Estimate, Dr. Weibe found that Plaintiff's
2 "premorbid overall IQ is estimated to be below average." *Id.* at 527. Regarding Plaintiff's abilities
3 in the domains of attention, concentration, and calculation (as measured by the RBANS, the
4 MMSE, and Part A of the TMT) Dr. Weibe found that Plaintiff suffers from severe impairments as
5 evidenced by the fact that he could not do single-digit arithmetic operations without the use of
6 visual aids, as well as by the fact that he was unable to spell a five-letter word ("world")
7 backwards. *Id.* She also found Plaintiff to be severely impaired in his ability to plan, sequence,
8 abstract, and organize based on his AMMSE performance, his inability to even complete Part B of
9 the TMT, and his inability to draw the hands of a clock at the correct time in the Clock-Drawing
10 Test. *Id.* Dr. Weibe also found that Plaintiff's linguistic faculties and his memory are also severely
11 impaired in that his performance on the RBANS indicated immediate and delayed memory
12 functions in the extremely low range (that is, below the 0.1 percentile). *Id.* at 527-28. Conversely,
13 Dr. Weibe found that Plaintiff was unimpaired in the domain of visual/spatial abilities, and that he
14 functioned with mild impairment in the domain of sensory/motor abilities. *Id.* at 528.

15 Plaintiff's emotional function – as measured by the Beck Depression and Anxiety
16 Inventories – paints a disturbing picture. *Id.* at 528-31. Test results in this domain were indicative
17 that Plaintiff suffers from severe depression while experiencing moderate anxiety. *Id.* at 528-29.
18 When asked how he was feeling during Dr. Weibe's assessment, Plaintiff responded: "I want to
19 kill myself – get away from everybody." *Id.* at 529. When asked if he could recall the first time
20 that he felt that way, Plaintiff responded that he first wished he were dead at the age of five or six
21 when he found out he has no family, and that since then, on numerous occasions "he has felt bad
22 enough to want to kill himself." *Id.* To that end, Plaintiff reported having cut his arm as part of an
23 attempted suicide about a year before the session with Dr. Weibe (i.e., on or about August of
24 2016). Plaintiff also reported his several-year history of auditory hallucinations which largely
25 consist of command hallucinations (that is, voices that tell him to do things, some of which are
26 good while others are not) as well as derogatory auditory hallucinations (such as voices that
27 ridicule him). *Id.* at 530. Plaintiff also experiences visual hallucinations (such as seeing "goat ears
28 on a jacket") which he interprets as "God let[ting] me see stuff other people don't see." *Id.*

1 In describing Plaintiff's "unresolved inner conflicts, with [a] history of complex trauma
2 from childhood," Dr. Weibe reported that Plaintiff was the victim of sexual abuse as a child
3 (between the ages of 5 and 7), and that even discussing his trauma causes him a great deal of
4 distress. *Id.* at 531. In short, Dr. Weibe opined that Plaintiff's history of trauma is rooted in those
5 episodes of childhood sexual abuse, his history of problems with learning and cognition, his being
6 made to witness the beatings his mother suffered at his father's hands during his formative years,
7 his being afflicted with chronic homelessness during large portions of his childhood and
8 adolescence, his long-term struggles with depression, anxiety, and attention, as well as his
9 experiences with command and derogatory auditory hallucinations. *Id.* Due to these conditions,
10 and due to Plaintiff's "tendencies for cognitive and perceptual distortions," Dr. Weibe added that
11 Plaintiff experiences significant difficulties with social interactions, which require him to remain
12 socially withdrawn such as to make it difficult for him to even be "able to perform reliably and to
13 relate and communicate effectively with supervisors, co-workers, and the public in a work
14 environment." *Id.* at 531-32. In short, Dr. Weibe diagnosed Plaintiff with: an unspecified trauma
15 and stressor-related disorder; a recurrent-episode major depressive disorder with psychotic
16 features and anxious distress; an unspecified intellectual disability; a schizoaffective disorder of
17 the depressive type; PTSD; and, kleptomania. *Id.* at 532. In essence, she concluded that Plaintiff's
18 various problems and impairments were interrelated and that each condition operates to worsen
19 the others in that his "cognitive functioning impairments appear to result from [a] history of
20 learning problems including likely intellectual disability since childhood[,] as well as his
21 psychiatric problems including psychosis, depression, anxiety, and trauma and stressor-related
22 symptoms." *Id.* On the basis of these diagnostic impressions and attendant findings and test
23 results, Dr. Weibe opined that Plaintiff's "psychiatric and cognitive problems will likely impair his
24 ability to work for at least two years." *Id.*

25 Treating Psychologist

26 The following year, on January 19, 2018, Plaintiff's treating psychologist and his social
27 worker at the Lifelong Trust Health Center in Oakland, California, jointly completed and
28 submitted a Mental Impairment Questionnaire on Plaintiff's behalf. *Id.* at 536-40. Therein, Ted

1 Aames, Ph.D., and Kari Jennings-Parriott, LCSW, noted that Plaintiff had been under their care
2 since April of 2016 with twice-monthly psychotherapy sessions for a period spanning nearly two
3 years. *Id.* at 536. At the outset, Dr. Aames noted that his opinions as to Plaintiff's functioning
4 were based on the course of his treatment as well as Plaintiff's history and medical file, the
5 psychological evaluations and reports of other examiners, progress notes and office notes, as well
6 as consultations with the supervising psychologist at the Lifelong Trust Health Center. *Id.* In this
7 regard, Dr. Aames noted that Plaintiff's major depressive disorder has lasted and is expected to
8 last more than 12 months, and that its severity interferes even with the basic activities of daily
9 functioning. *Id.* Dr. Aames then catalogued the 21 consequential symptoms of Plaintiff's disorder
10 as: significant deficits in complex attention, executive function, learning and memory; delusions
11 or hallucinations; diminished interest in nearly all activities; sleep disturbance; decreased energy;
12 difficulty concentrating or thinking; frequent distractibility; fatigue; involuntary and time-
13 consuming preoccupation with intrusive and unwanted thoughts; detachment from social
14 relationships; difficulty organizing tasks; disorganized thinking; depressed mood; thoughts of
15 death or suicide; restlessness; irritability; distrust or suspiciousness of others; disproportionate fear
16 or anxiety amounting to agoraphobia; inability in maintaining interpersonal relationships;
17 difficulty in sustaining attention; and disturbances in mood and behavior. *Id.* at 537.

18 At bottom, Dr. Aames concluded that Plaintiff's abilities to function in *every* category of
19 work-related function were attended with marked limitation (meaning that his ability to function
20 was seriously limited, in that his performance in each of those categories would be precluded by
21 more than 20%). *Id.* at 538-39. Thus, Dr. Aames opined that Plaintiff suffered marked limitations
22 in the following areas: his ability to understand, remember, and apply information; his ability to
23 interact with others; his ability to concentrate, persist, or maintain pace; and, his ability to adapt or
24 manage himself. *Id.* Consequently, Dr. Aames opined that Plaintiff would be expected to be absent
25 from work (as a result of his symptoms or his need for treatment) for more than 4 days per month,
26 and that he should be expected to be off-task or precluded from functioning during more than 30%
27 of any given workday. *Id.* at 539. Lastly, Dr. Aames noted that Plaintiff's conditions combine to
28 minimize his capacity to adapt to changes in his environment or to demands that are not already

1 part of his daily life. *Id.* at 540.

2 Non-Examining State Agency Consultants

3 In February of 2016, H. Amado, M.D., a non-examining state agency consultant reviewed
4 Dr. Howard's report, as well as some unspecified quantity of Plaintiff's medical records and
5 rendered a number of opinions which appear to contradict one another to a significant degree. *See*
6 AR at 197-207. First, it was noted that another consultative examination might be necessary
7 because “[t]he evidence as a whole, both medical and non-medical is not sufficient to support a
8 decision on the claim,” despite the fact that Dr. Howard had performed exactly such an
9 examination the previous month and Dr. Amado had reviewed that report. *Id.* at 200, 203.
10 Confusingly, Dr. Amado explained his opinion as being based on giving “great weight” to Dr.
11 Howard’s opinion because Dr. Howard’s opinion was congruent with both the medical evidence
12 of record and with the objective results of the administered tests. *Id.* at 204. Leaving little room for
13 ambiguity, Dr. Amado then repeated the fact that Dr. Howard had opined that Plaintiff experiences
14 marked limitations in performing even simple tasks, as well as marked limitations in working with
15 supervisors, coworkers, and the public. *Id.* at 201. Then, without any identifiable explanation, and
16 despite claiming to have given Dr. Howard’s opinion “great weight,” and despite noting that the
17 evidence was insufficient to support a decision on the claim, Dr. Amado somehow opined that
18 Plaintiff was “not significantly limited” in nearly all of the categories of work-related functioning
19 and concluded that “[w]ith psych treatment and abstinence from daily cannabis use [], it is
20 stipulated that claimant’s potentially treatment-responsive psych condition will improve and
21 permit simple work on a sustained basis.” *Id.* at 204-06. It should be noted that Dr. Amado’s
22 opinion significantly predicated the opinion of Dr. Weibe and the entire course of Plaintiff’s
23 treatment with Dr. Aames, which culminated in the above-discussed report co-authored by Dr.
24 Aames in 2018.

25 Hearing Testimony

26 In pertinent part, at the hearing on this claim, the ALJ asked the Vocational Expert (“VE”)
27 whether a person of Plaintiff’s age, education, and experience could perform simple work at the
28 medium exertional level. *Id.* at 194. The ALJ further limited the “simple work” to which Plaintiff

1 might be relegated as such that would be routine, repetitive, and limited by occurring in a low-
2 stress environment in that there would be only occasional decision-making, occasional changes in
3 the work setting, and only occasional (or no) interaction with the general public. *Id.* at 194-95. The
4 VE answered in the affirmative and posited that such a person would be able to fulfill the
5 requirements of a laundry worker, a hand packager, or a floor waxer. *Id.* at 195. When the VE was
6 asked whether there would be any possibility of employment in the national economy for such a
7 person but with an allowance for that person to be off-task 25% of the workday while being
8 allowed to miss work entirely “at least three times a month unscheduled and unexcused,” the VE
9 responded in the negative. *Id.* at 196.

10 **THE FIVE STEP SEQUENTIAL ANALYSIS FOR DETERMINING DISABILITY**

11 A person filing a claim for social security disability benefits (“the claimant”) must show
12 that he has the “inability to do any substantial gainful activity by reason of any medically
13 determinable physical or mental impairment” which has lasted or is expected to last for twelve or
14 more months. *See* 20 C.F.R. §§ 416.920(a)(4)(ii), 416.909. The ALJ must consider all evidence in
15 the claimant’s case record to determine disability (*see id.* § 416.920(a)(3)), and must use a five-
16 step sequential evaluation process to determine whether the claimant is disabled (*see id.* §
17 416.920). “[T]he ALJ has a special duty to fully and fairly develop the record and to assure that
18 the claimant’s interests are considered.” *Brown v. Heckler*, 713 F.2d 441, 443 (9th Cir. 1983).

19 Here, the ALJ set forth the applicable law under the required five-step sequential
20 evaluation process. *AR* at 12-13. At Step One, the claimant bears the burden of showing he has not
21 been engaged in “substantial gainful activity” since the alleged date on which the claimant became
22 disabled. *See* 20 C.F.R. § 416.920(b). If the claimant has worked and the work is found to be
23 substantial gainful activity, the claimant will be found not disabled. *See id.* The ALJ found that
24 Plaintiff had not engaged in substantial gainful activity since the alleged onset date. *AR* at 13. At
25 Step Two, the claimant bears the burden of showing that he has a medically severe impairment or
26 combination of impairments. *See* 20 C.F.R. § 416.920(a)(4)(ii), (c). “An impairment is not severe
27 if it is merely ‘a slight abnormality (or combination of slight abnormalities) that has no more than
28 a minimal effect on the ability to do basic work activities.’” *Webb v. Barnhart*, 433 F.3d 683, 686

1 (9th Cir. 2005) (quoting S.S.R. No. 96-3(p) (1996)). At Step Two, the ALJ found that Plaintiff
2 suffered from the following severe impairments: intellectual disability, recurrent and severe major
3 depressive disorder with psychotic symptoms, and a mood disorder. *Id.* at 13-14. However, the
4 ALJ failed to even mention, let alone discuss and analyze, Plaintiff's diagnoses for PTSD and
5 schizoaffective disorder of the depressive type.

6 At Step Three, the ALJ compares the claimant's impairments to the impairments listed in
7 appendix 1 to subpart P of part 404. *See* 20 C.F.R. § 416.920(a)(4)(iii), (d). The claimant bears the
8 burden of showing his impairments meet or equal an impairment in the listing. *Id.* If the claimant
9 is successful, a disability is presumed and benefits are awarded. *Id.* If the claimant is unsuccessful,
10 the ALJ assesses the claimant's residual functional capacity ("RFC") and proceeds to Step Four.
11 *See id.* § 416.920(a)(4)(iv), (e). Here, the ALJ found that Plaintiff did not have an impairment or
12 combination of impairments that met or medically equaled the severity of any of the listed
13 impairments. *AR* at 13-16. Next, the ALJ determined that Plaintiff retained the RFC to perform
14 work at the medium exertional level but limited to simple, routine, and repetitive tasks, while
15 working in a low stress job involving only occasional decision-making and occasional changes in
16 the work setting; and, further limited to having no interactions with the general public, while
17 having only occasional interactions with co-workers. *Id.* at 16-21.

18 At Step Four, the ALJ determined that Plaintiff is unable to perform his past relevant work
19 because he has no past relevant work. *Id.* at 21. Lastly, at Step Five, the ALJ concluded, based on
20 the RFC, Plaintiff's age, education, and the VE's testimony, that there are jobs that exist in
21 significant numbers which Plaintiff could perform – namely, the ALJ found that Plaintiff could
22 perform the functions of a floor waxer, a hand packer, or a laundry worker. *Id.* at 21-22. Thus, the
23 ALJ then concluded that Plaintiff had not been under a disability, as defined in the Social Security
24 Act, since September 16, 2015, the date the application was filed. *Id.* at 22.

25 DISCUSSION

26 Based on the record as described above, Plaintiff submits that this case satisfies the
27 conditions of the credit-as-true doctrine: because the ALJ failed to provide legally sufficient
28 reasons for rejecting this evidence; because, when properly credited, the evidence would require

1 the ALJ to find Plaintiff disabled on remand; because there are no outstanding issues that need to
2 be resolved before a disability determination may be rendered; and, because a review of the record
3 as a whole does not give rise to any serious doubt that Plaintiff is, in fact, disabled. *See* Pl.’s Mot.
4 (dkt. 38) at 23. Defendant agrees that the case is due to be remanded because the ALJ’s
5 “subjective complaint and medical opinion analysis is deficient.” Def.’s Mot. (dkt. 39) at 1.
6 However, Defendant contends that “[w]hile there is evidence of some positive psychiatric
7 symptoms, the record also contains numerous examinations showing normal memory, orientation,
8 and judgment,” which in Defendant’s view are “outstanding issues [that] must be resolved through
9 further administrative proceedings.” *Id.* at 2. In support of the argument as to the necessity for
10 further proceedings, Defendant notes: (1) that Dr. Dixit’s 2016 opinion reached the conclusion that
11 Plaintiff’s work-related abilities are attended with little to no limitations; (2) that Helen Patterson,
12 Ph.D., a non-examining consultant, reviewed Plaintiff’s file in September of 2016, and opined that
13 Plaintiff’s conditions were attended with “mild limitations only”; and (3) that while Plaintiff had
14 told some person, in 2015, that he does not shop for food, prepare meals for himself, or care for
15 animals – Plaintiff’s friend reported that he does on occasion shop for food, that he sometimes
16 “makes himself sandwiches and uses the microwave,” and “that he takes care of a kitten.” *See id.*
17 at 4-5. Defendant also places great emphasis on seeking out various statements by Plaintiff that, in
18 Defendant’s view, tend to contradict the limitations opined by Drs. Weibe and Aames. *See id.* at 5-
19 7. As to the last contention, Defendant is essentially grasping at straws by attempting to find
20 avenues where further administrative proceedings are necessitated where none exist such as by
21 noting that “[d]espite allegations of not being able to be around people, Plaintiff told his treatment
22 providers [that] he spends ‘most of his days doing or selling his art.’” *Id.* at 6. Or, by way of
23 another example, Defendant posits that further administrative proceedings are necessary because,
24 in 2016, Plaintiff reportedly told Dr. Dixit that he could shop for food, whereas, in 2017, he
25 reportedly told Dr. Weibe that he does not shop for food. *Id.* In short, based on reasoning of this
26 sort – that is, in order to solve such mysteries as whether or not Plaintiff has ever made himself
27 sandwiches, used a microwave oven, or cared for a kitten – Defendant submits that further
28 administrative proceedings are needed. For the reasons discussed below, the court disagrees.

Initially, the court will note that the ALJ in this case rejected the non-examining consultative opinion rendered by Dr. Patterson “because she did not have the opportunity to examine the claimant or to consider the entire record.” AR at 20. Accordingly, Defendant’s reliance on the fact that, in 2016, two non-examining consultants (Drs. Amado and Patterson) – having reviewed an unspecified portion of Plaintiff’s medical file – opined that Plaintiff suffers only from mild limitations is unpersuasive (if only for the reasons that the ALJ gave when rejecting Dr. Patterson’s opinion). As to the notion of making sandwiches, using a microwave, or caring for a kitten, these are not inconsistencies for which further administrative proceedings are necessary because no matter how many sandwiches Plaintiff has made, or how much time he has spent caring for a kitten, these are not the sorts of activities that can (to any degree) undercut the opinions expressed by Drs. Weibe, Howard, and Aames. In fact, the only record-evidence that warrants any discussion whatsoever in this context is the opinion rendered in August of 2016 by Dr. Dixit, in which she opined that Plaintiff’s conditions are attended with little to no limitations at all. In this case, the ALJ rejected the opinions rendered by Drs. Howard, Weibe, and Aames while giving controlling weight to the opinions of Dr. Dixit and one of the two non-examining state agency consultants (Dr. Amado). *See AR at 19-20.*

Medical opinions are “distinguished by three types of physicians: (1) those who treat the claimant (treating physicians); (2) those who examine but do not treat the claimant (examining physicians); and (3) those who neither examine nor treat the claimant (nonexamining physicians).” *Lester v. Chater*, 81 F.3d 821, 830 (9th Cir. 1995). The medical opinion of a claimant’s treating provider is given “controlling weight” so long as it “is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the claimant’s] case record.” 20 C.F.R. § 404.1527(c)(2); *see also Revels*, 874 F.3d at 654. In cases where a treating doctor’s opinion is not controlling, the opinion is weighted according to factors such as the nature and extent of the treatment relationship, as well as the consistency of the opinion with the record. 20 C.F.R. § 404.1527(c)(2)-(6); *Revels*, 874 F.3d at 654.

“To reject [the] uncontradicted opinion of a treating or examining doctor, an ALJ must

1 state clear and convincing reasons that are supported by substantial evidence.” *Ryan v. Comm’r of*
2 *Soc. Sec.*, 528 F.3d 1194, 1198 (9th Cir. 2008) (alteration in original) (quoting *Bayliss v. Barnhart*,
3 427 F.3d 1211, 1216 (9th Cir. 2005)). “If a treating or examining doctor’s opinion is contradicted
4 by another doctor’s opinion, an ALJ may only reject it by providing specific and legitimate
5 reasons that are supported by substantial evidence.” *Id.* (quoting *Bayliss*, 427 F.3d at 1216); *see*
6 *also Reddick v. Chater*, 157 F.3d 715, 725 (9th Cir. 1998) (“[The] reasons for rejecting a treating
7 doctor’s credible opinion on disability are comparable to those required for rejecting a treating
8 doctor’s medical opinion.”). “The ALJ can meet this burden by setting out a detailed and thorough
9 summary of the facts and conflicting clinical evidence, stating his [or her] interpretation thereof,
10 and making findings.” *Magallanes v. Bowen*, 881 F.2d 747, 751 (9th Cir. 1989) (quoting *Cotton v.*
11 *Bowen*, 799 F.2d 1403, 1408 (9th Cir. 1986)). Further, “[t]he opinion of a nonexamining physician
12 cannot by itself constitute substantial evidence that justifies the rejection of the opinion of either
13 an examining physician or a treating physician.” *Lester*, 81 F.3d at 831; *see also Revels*, 874 F.3d
14 at 654-55; *Widmark v. Barnhart*, 454 F.3d 1063, 1066-67 n.2 (9th Cir. 2006); *Morgan v. Comm’r*,
15 169 F.3d 595, 602 (9th Cir. 1999); *see also Erickson v. Shalala*, 9 F.3d 813, 818 n.7 (9th Cir.
16 1993). In situations where a Plaintiff’s condition progressively deteriorates, the most recent
17 medical report is the most probative. *See Young v. Heckler*, 803 F.2d 963, 968 (9th Cir. 1986).

18 It will not be necessary to determine whether or not the later-rendered findings and
19 opinions of Dr. Aames (Plaintiff’s treating psychologist) and Dr. Weibe (examining consultant)
20 were “contradicted” by the earlier-rendered opinion of Dr. Dixit because the ALJ’s explanations
21 for rejecting this evidence did not even rise to the standard of specific and legitimate reasons
22 supported by substantial evidence because, in light of the record as a whole (namely, Dr. Aames’s
23 extensive several-year treatment relationship with Plaintiff, coupled with the consistent opinions
24 rendered by Drs. Weibe and Howard) it cannot be reasonably said that Dr. Dixit’s outlier and
25 conclusory opinion, by itself, constitutes “substantial evidence.” Or, put another way, it is simply
26 not possible to conclude – in light of the test results, findings, and consistent opinions rendered by
27 Drs. Howard, Weibe, and Aames – that Dr. Dixit’s opinion by itself can be characterized as “such
28 relevant evidence as a reasonable mind might accept as adequate to support a conclusion” to the

1 effect that Plaintiff's conditions are attended with little to no limitations. *See Biestek*, 139 S. Ct. at
2 1154.

3 The ALJ in this case made no shortage of errors. First, the ALJ failed to consider
4 Plaintiff's PTSD and schizoaffective disorder at Step Two and beyond. *See AR* at 13-14. Second,
5 it was error for the ALJ to give controlling weight to the opinions of Dr. Dixit and Dr. Amado, the
6 non-examining consultant, and to exclusively base the Step Three analysis and the RFC findings
7 on those opinions given the fact that they are contradicted by the overwhelming weight of the
8 medical evidence as discussed above. Further, as mentioned above, those opinions cannot by
9 themselves constitute substantial evidence that justifies the rejection of the consistent and well-
10 founded opinions of Plaintiff's treating physician, as confirmed and corroborated by two
11 independent examining physicians. In short, the ALJ's decision to reject the opinions of Drs.
12 Aames, Weibe, and Howard rested on the faulty reasoning described above as well as a near-
13 complete misapprehension of the record. Nor are these opinions in any way called into question by
14 the making of sandwiches, the use of a microwave oven, the occasional production and selling of
15 drawings, or providing care for a kitten. Accordingly, the court now finds that the opinions of Drs.
16 Aames, Weibe, and Howard are due to be credited-as-true as a matter of law.

17 **Nature of Remand**

18 The decision whether to remand for further proceedings or for payment of benefits
19 generally turns on the likely utility of further proceedings. *Carmickle v. Comm'r, SSA*, 533 F.3d
20 1155, 1169 (9th Cir. 2008). A district court may "direct an award of benefits where the record has
21 been fully developed and where further administrative proceedings would serve no useful
22 purpose." *Smolen*, 80 F.3d at 1292.

23 The Court of Appeals for the Ninth Circuit has established a three-part test "for
24 determining when evidence should be credited and an immediate award of benefits directed."
25 *Harman v. Apfel*, 211 F.3d 1172, 1178 (9th Cir. 2000). Remand for an immediate award of
26 benefits is appropriate when: (1) the ALJ has failed to provide legally sufficient reasons for
27 rejecting such evidence; (2) there are no outstanding issues that must be resolved before a
28 determination of disability can be made; and, (3) it is clear from the record that the ALJ would be

1 required to find the claimant disabled were such evidence credited. *Id.* The second and third
2 prongs of the test often merge into a single question; that is, whether the ALJ would have to award
3 benefits if the case were remanded for further proceedings. *Id.* at 1178 n.2; *see also Garrison v.*
4 *Colvin*, 759 F.3d 995, 1021-23 (9th Cir. 2014) (when all three conditions of the credit-as-true rule
5 are satisfied, and a careful review of the record discloses no reason to seriously doubt that a
6 claimant is, in fact, disabled, a remand for a calculation and award of benefits is required). Here, in
7 light of the above-discussed and improperly discredited medical opinion evidence, two things are
8 clear: first, it is clear that Plaintiff has in fact been disabled since his alleged onset date, and
9 second, it is clear that further administrative proceedings would be useless because the ALJ would
10 be required to find Plaintiff disabled on remand. Plaintiff's major depressive disorder, his PTSD,
11 and his intellectual disability would undoubtedly compel independent disability findings at Step
12 Three because they each clearly meet the criteria for the three relevant listings, to wit: Listing
13 12.04(A)(1) (depressive disorder), Listing 12.15 (trauma-related disorders), and Listing 12.05
14 (intellectual disorder)). *See* 20 C.F.R. Pt. 404, Subpt. P, app. 1, §§ 12.04, 12.05, 12.15.

15 The first reason that further administrative proceedings would be useless is that based on
16 the improperly discredited evidence, Plaintiff's condition clearly meets the criteria of Listing
17 12.04(A)(1) pertaining to depressive disorders. *See* 20 C.F.R. Pt. 404, Subpt. P, App. 1, §12.04.
18 To satisfy the criteria of Listing 12.04 – it is necessary to satisfy the pertinent criteria listed in
19 subparts (A)(1) and (B), or (A)(1) and (C). *See id.* Subpart (A) requires medical documentation of
20 a depressive disorder, characterized by five or more of the following: depressed mood; diminished
21 interest in almost all activities; appetite disturbance with change in weight; sleep disturbance;
22 observable psychomotor agitation or retardation; decreased energy; feelings of guilt or
23 worthlessness; difficulty concentrating or thinking; or thoughts of death or suicide. § 12.04(A). As
24 discussed above, Drs. Aames, Howard, and Weibe found that Plaintiff met eight of these criteria,
25 basically every category with the exception of disturbances of the appetite. *See AR* at 525-31, 537.
26 Turning to Subpart (B) of Listing 12.04, that provision requires: extreme limitation of one, or
27 marked limitation of two, of the following areas of mental functioning: understanding,
28 remembering, or applying information; interacting with others; concentrating, persisting, or

1 maintaining pace; adapting or managing oneself. § 12.04(B). Drs. Aames, Howard, and Weibe
2 found marked limitations in all four of these categories. *See AR* at 427, 535, 538-39. Thus,
3 Plaintiff's depression has clearly been disabling under Listing 12.04(A)(1) and (B) since his
4 alleged onset date.

5 The second reason that further administrative proceedings would be useless is that
6 Plaintiff's PTSD also meets or equals the criteria of Listing 12.15. As was the case above, in order
7 to satisfy the criteria for listing-level PTSD under §12.15 – it is necessary to satisfy the pertinent
8 criteria listed in subparts (A) and (B), or (A) and (C). *See* 20 C.F.R. Pt. 404, Subpt. P, App. 1,
9 §12.15. The first part of Listing 12.15(A) requires meeting all of the following criteria: exposure
10 to actual or threatened death, serious injury, or violence; subsequent involuntary re-experiencing
11 of the traumatic event (e.g., intrusive memories, flashbacks, or dreams); avoidance of external
12 reminders of the event; disturbances in mood and behavior; and, increases in arousal and reactivity
13 (e.g., exaggerated startle response or sleep disturbance). *Id.* Once again, as discussed above, Drs.
14 Aames and Weibe found that Plaintiff met all of these criteria as a result of the interaction between
15 the trauma he experienced due his childhood sexual abuse, his early years spent witnessing the
16 violent beatings his mother suffered at his father's hands, his chronic homelessness, his
17 intellectual disability, "as well as his psychiatric problems including psychosis, depression,
18 anxiety, and trauma and stressor related symptoms." *See AR* at 523-35, 537-40. Subpart (B) has
19 the same requirements and criteria discussed above; and, again, Drs. Aames, Howard, and Weibe
20 found marked limitations in all four categories. *See id.* at 427, 535, 537. Accordingly, Plaintiff's
21 PTSD has also been clearly disabling under Listing 12.15(A) and (B) since his alleged onset date.

22 The third reason that further administrative proceedings would constitute nothing more
23 than waste of time is that Plaintiff's intellectual disorder also clearly meets or equals the criteria
24 set forth in Listing 12.05(B). In order to satisfy the criteria for listing-level intellectual disorder
25 under §12.05 – it is necessary to satisfy the pertinent criteria listed in either subpart (A) or (B). *See*
26 20 C.F.R. Pt. 404, Subpt. P, App. 1, §12.05. The criteria set forth in Subpart (B) require a full
27 scale IQ score of 70 or below; significant deficits in adaptive functioning currently manifested by
28 extreme limitation of one, or marked limitation of two of the following areas of mental

functioning: understanding, remembering, or applying information; interacting with others; concentrating, persisting, or maintaining pace; and adapting or managing oneself – additionally, the evidence about the current level of intellectual and adaptive functioning should demonstrate or support the conclusion that the disorder began prior to the age of 22. *See id.* at §12.05(B)(1)-(3). In this regard, in January of 2016, Dr. Howard’s administering of the WAIS-IV resulted in a full scale IQ score of 61 (*see AR* at 426); and, as mentioned above, Drs. Wiebe, Howard, and Aames found marked limitations in all four of the areas of mental functioning. *See id.* at 427, 535, 538-39. As to evidence of the onset of the disorder prior to the age of 22, Dr. Howard noted that Plaintiff was engaged “in unspecified special education classes in school for learning problems.” *Id.* at 424. Additional support is found for this conclusion in Dr. Wiebe’s findings to the same effect (*see id.* at 523 “[h]e was teased in school for being slow, being tall, and being in slow classes,” *see also id.* at 524 “he was in special education and resource classes for having problems with memory and slow functioning,” *see also id.* at 525-26 “presenting as very childish, immature, and teenage-like,” *see also id.* at 531 “[h]e has long term problems with depression, anxiety, learning, and attention,” and, *see also id.* at 532 “[his] cognitive functioning impairments appear to result from [a] history of learning problems including likely intellectual disability since childhood.”). Thus, Plaintiff’s intellectual disorder has also been clearly disabling under Listing 12.05(B) since his alleged onset date.

As for the fourth reason that the record conclusively establishes that Plaintiff has been disabled since his alleged onset date, even if one were able to overlook the fact that his mental impairments clearly satisfy the above-described listings, the combination of his mental impairments would also compel a disability finding during the formulation of the RFC. Given the fact that the improperly rejected evidence established marked limitations in all of the areas of mental functioning, the inescapable conclusion is that Plaintiff has had no residual capacity to function in the workplace at all. This conclusion would be compelled by Dr. Wiebe’s finding that Plaintiff’s “psychiatric and cognitive problems will likely impair his ability to work for at least two years.” *AR* at 532. Similarly, Dr. Aames found that even with medication and psychotherapy, Plaintiff can be expected to show only marginal adjustment in that he has only a minimal capacity

1 to adapt to changes in his environment or to demands that are not already part of his daily life. *Id.*
2 at 540.

3 Turning to the fifth and final reason that further proceedings would be futile – when the
4 improperly rejected evidence is given effect, the ALJ would be required to find Plaintiff disabled
5 at Step Five based on the VE’s testimony. As mentioned above, at the hearing before the ALJ,
6 when the VE was asked whether there would be any possibility of employment in the national
7 economy for a person such as Plaintiff but with an allowance for that person to be off-task 25% of
8 the workday while being allowed to miss work entirely “at least three times a month unscheduled
9 and unexcused,” the VE responded in the negative. *Id.* at 196. Given that Dr. Aames concluded
10 that Plaintiff would be off-task more than 30% of the time, and that he would be absent from work
11 due to his symptoms or treatment more than 4 days per month (*see id.* at 539), then a disability
12 finding at Step Five based on the VE testimony would be unavoidable because if there is no work
13 for a person who is off-task for 25% of the time and absent 3 days per month, then there is
14 definitely no work for a person who will be off-task and absent to a greater degree than that. Thus,
15 on remand, Plaintiff would also be found disabled at Step Five based on the testimony of the VE.

16 At this juncture, the court will note that in cases where each of the credit-as-true factors is
17 met, it is generally only in “rare instances” where a review of the record as a whole gives rise to a
18 “serious doubt as to whether the claimant is actually disabled.” *Revels*, 874 F.3d at 668 n.8 (citing
19 *Garrison*, 759 F.3d at 1021). This is not one of those “rare instances,” as the record leaves no
20 room to doubt that Plaintiff has in fact been disabled, at least since his alleged onset date, if not
21 much earlier. Needlessly remanding a disability claim for further unnecessary proceedings would
22 only delay much needed income for claimants such as Plaintiff who are unable to work and who
23 are entitled to benefits; doing so would in turn subject them to “tremendous financial difficulties
24 while awaiting the outcome of their appeals and proceedings on remand.” *Varney v. Sec’y of*
25 *Health & Human Servs.*, 859 F.2d 1396, 1398 (9th Cir. 1988). Thus, the law in this Circuit does
26 not permit a case like this to be remanded for no reason other than to allow an ALJ a nugatory
27 opportunity to inquire into trivial details of the sort that Defendant has mentioned, or even for a
28 needless attempt at finding out why Dr. Dixit’s opinion stood in such contrast to the opinions of

1 Plaintiff's treating psychotherapist (Dr. Aames) and two independent examining psychologists
2 (Drs. Wiebe and Howard). The court is satisfied that Dr. Dixit's opinion was thoroughly negated
3 by the overwhelming tide of the record evidence in this case and that no further inquiry is
4 necessary in that regard. Therefore, at this juncture, and given the state of the record in this case,
5 the court can conceive of no legitimate reason for any further administrative proceedings, as
6 Plaintiff is undoubtedly disabled and therefore in dire need of financial assistance. *See Benecke*,
7 379 F.3d at 595 ("Allowing the Commissioner to decide the issue again would create an unfair
8 'heads we win; tails, let's play again' system of disability benefits adjudication.").

9 **CONCLUSION**

10 Accordingly, for the reasons stated above, Plaintiff's Motion for Summary Judgment (dkt.
11 38) is **GRANTED**, and Defendant's Cross-Motion seeking remand for further proceedings (dkt.
12 39) is **DENIED**. The ALJ's finding of non-disability is **REVERSED** and the case **REMANDED**
13 for the immediate calculation and payment of appropriate benefits.

14 **IT IS SO ORDERED.**

15 Dated: March 9, 2021

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ROBERT M. ILLMAN
United States Magistrate Judge